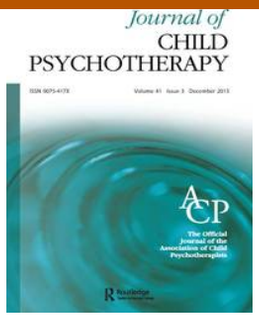

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'Paralysed associations': countertransference difficulties in recognising meaning in the treatment of children on the autistic spectrum

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Children with autism can have a paralysing effect on the clinician's capacity to associate freely: connections that seem obvious on reflection may be impossible to notice in the child's presence. The author argues that this situation can be reached by more than one pathway, and that the degree of the child's bodily and emotional cohesion is an important factor. Children may seek to immobilise the therapist's thought processes through projective identification, whether to communicate their own experience of paralysis or because these thought processes are equated with a parental intercourse that produces a 'baby' (as described by Bion and Britton). Vignettes are offered to illustrate how the therapist may be nudged into overlooking this baby as well as a potentially growing part of the child that is identified with it, with important consequences for development. A second possible pathway appears to involve the much more primitive mechanism of adhesive identification, in which the child's sense of continuing existence depends on sticking to the therapist's surface and any movement can lead to a sense of bodily disintegration. In the clinical illustration, the therapist felt physically constrained and unable to recognise links in the material: it is suggested that this was in resonance with the child's fear that movement, whether physical or mental, meant losing parts of his body and must be avoided at all costs. These levels can mask each other, and it seems essential to attend to both in order to avoid impasse or the overlooking of essential aspects of the child's experience.

Keywords: adhesive resonance; countertransference; meaning; paralysis of thought; projective identification

My aim in this paper is to describe the paralysis of the capacity to think and to recognise meaningful patterns that clinicians working with children on the autistic spectrum often experience, and to illustrate two of the countertransference pathways that can lead to this situation. Such paralysis is of course far from unique to autism, but it does occur very frequently in the treatment of children on the spectrum. The proportion of the work that is affected varies; at its worst, the clinician can spend much of the time in a state of hopelessness about being able to recognise any meaningful links or even to search for any possible approach to the difficulty.

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Melanie Klein, in her 1930 paper on 'The importance of symbol formation in the development of the ego', wrote that she had to take an active role in getting her four-year-old autistic patient Dick's analysis underway by describing two toy trains as the 'Daddy train' and the 'Dick train'. Since then, most writers on autism, including Tustin (1972), Meltzer (1975: 15) and particularly Alvarez (1980), have agreed that the clinician often needs to be more active than usual if contact is to be established. But there are some cases in which it feels impossible to imagine any way in which one could conceivably be active. Interpreting this as a countertransference communication may not elicit any response. It can be a small step from recognising that this was not meaningful for the child, to feeling that nothing possibly ever could be and to finding oneself in an impasse in which important facets of the child's experience and behaviour are overlooked.

In attempting to understand how this may come about, I will discuss material from three children. Of the various pathways that can lead to the clinician's inability to make links and recognise patterns, I will focus on the impact of projective identification and adhesive identification, and I will suggest that the extent of bodily and emotional cohesion that the child has achieved exerts an important influence on which pathway seems to predominate.

Some children have developed sufficiently to make use of projective identification in order to affect the clinician's thought processes. This may serve to communicate their own experience of being unable to make links; it can also happen because these thought processes are equated with a parental intercourse that produces a 'baby' (Bion, 1959; Britton, 1989). Material from a child, Sasha, which I discuss later in the paper illustrates how the link between the parents can be experienced concretely as a privileged baby whose existence leaves no room for the child. The clinician may then be nudged to overlook the presence of this 'baby', as though responding to the child's wish for it not to exist (a process that Spillius (1988: 83) has called 'evocatory projective identification').[1] I believe that this happened in the session I will refer to, where the therapist, very uncharacteristically, did not notice what looked like a baby in one of the child's drawings. This can mean that the potentially growing part of the child, which is identified with the 'baby', may be overlooked as well.

While this can be very striking, it is far less extreme than the clinician's experience of paralysis in cases where the much more primitive mechanism of adhesive identification seems to predominate. Bick (1968, 1986) has described how the child's sense of continuing existence can depend on feeling 'stuck' to surface qualities of the therapist, so that any movement towards separation either mental or physical can lead to an experience of falling apart physically as well as mentally. Durban (2014), in a paper on the analyst's oscillation between despair and hope in the treatment of ASD children, has suggested that this oscillation can in fact serve a vital function in the struggle against paralysis by opening up a three-dimensional mental space in the treatment. In my third clinical illustration, the therapist was overwhelmed by feeling physically constrained as well as mentally stuck and was unable to see any links in the material. I will suggest that this was a reflection of the child's fear that movement, whether physical or mental, meant losing parts of his body and therefore had to be avoided at all costs.

Before considering these two children whose therapists discussed them with me, I will begin by describing my own experience with Jacky, where both of these pathways seemed to be operating, with projective identification masking adhesive phenomena. It was not until I became aware of the primitive bodily level of his relationship to me

that I was able to achieve any kind of perspective on his projected communications. I will suggest more generally that children who appear not to be communicating may actually be doing so, but that the impact of their adhesive defences on the clinician can make it difficult to attain the distance from the material that is necessary in order to recognise these communications and respond to them.

Jacky: projective identification masking adhesive phenomena

Jacky was three years and nine months when he came to three times weekly treatment with a diagnosis of autism. At home, he spent all his waking hours 'galloping' up and down the room, making the same loud, vibrating sound – "deeee-eee-ee". His parents were heartbroken: as they said, "we can't get through to him at all". They lent me videos of his early life, which showed intense eye contact between him and his father soon after birth. When he was three months old, his maternal grandfather died at the same time as Jacky had corrective oral surgery. Further painful happenings followed, and the cumulative impact of the family's experiences seemed to be perpetuated in him on a fundamental, bodily level. For example, when his mother told me about her father's death, she began to cry. Jacky shrieked, his thumb shot out of his mouth, and he shook as though he were falling apart. It was as though his mother's emotional losses were equated with the loss of his own thumb and of his feeling of bodily coherence.

I realised of course that this little boy had had to endure experiences of extreme pain and vulnerability at a time when his parents were themselves vulnerable and unable to support him so much as they would have wished; but in the sessions I had to struggle with an upsurge of hatred when he reacted to anything I said by smirking triumphantly and galloping off. Attempts to interpret this as a communication, whether of helplessness, impotence, abandonment, or indeed hatred, all led nowhere, and I felt acutely that thinking of any meaningful link, let alone of any different or active approach, was completely beyond me.

For many months, Jacky watched me carefully as I walked from the door over to the table with his box, so that I could unlock the padlock and lift up the lid. He timed his own walk to the table so that he arrived just after I had opened the box, and he slammed down the lid with a triumphant grin. After that, other than galloping, he did nothing for 50 minutes, and I could think of nothing. Even if I did manage to construct an interpretation, this always felt contrived and it failed to convince me.

Then, one day, as I walked towards Jacky's box, I reached into the pocket of my overall in which I always kept the key, and it wasn't there. I stopped walking while I searched for it, and Jacky stopped too, with his eyes glued to me. When I finally found the key in another pocket and began to walk again, he did as well. He slammed down the lid as usual; but it felt completely different. It was a shock to realise that the way he shadowed my footsteps, which had felt so implacable and triumphant, in fact expressed the degree to which he was geared to me; and it softened my response to him. Very gradually, his own behaviour began to soften slightly. He produced some play that seemed to be meaningful; he could engage in a rudimentary game of rolling things back and forth between us; and I heard that he was involving himself more at school and using some words. Very occasionally my thought processes could escape his tyrannical control. For example, something he did made me think of a particular piece of music; one that was lively and full of rhythmical vitality. I felt able to tap out the rhythm, and he came over to watch with pleasure and fascination, though he soon reverted to his usual behaviour.

How might one understand this? Was it simply a matter of my finding it a bit easier to tolerate him once I had experienced his vulnerability on an emotional level, not just intellectually – once I had had a brief respite from having to be the one who was impotent, helpless and filled with hatred? Was he temporarily relieved to find that I was not always overwhelmed by hopelessness and depression; that my mental focus, like the key, could go missing and be found again, whereas his mother's bereavement seemed to have remained unresolved? Did the fact that I was thinking about who was in the grip of whom perhaps go some way towards loosening that grip, whoever was exerting it – I on him, as I now realised that he felt; he on my thought processes; a pathological organisation on his capacity to engage and develop? And what level of experience was being evoked? Jacky's triumphant smirk when he slammed his box shut had suggested to me that he was making use of projective identification to communicate a helplessness and hatred that he had found overwhelming, and that my difficulties largely stemmed from finding these feelings overwhelming too. But the degree to which his walk to the table was completely geared to mine, and the way his eyes were glued to me when the otherwise predictable opening to the session was disrupted, suggested something much more primitive and body-centred; something in the realm of adhesive identification as Bick (1968) described it, where the child feels that his survival depends on 'sticking' himself to the adult's physical or behavioural surface appearance.

Jacky's treatment could not be described as successful. Not much happened that helped to address my questions, though a good deal of material pointed to the severe anxieties about losing body parts or body contents that Tustin (1986) thought were typical of children on the autistic spectrum. It seemed clear that my extreme inability to make associative links was at least in part being elicited by him, but I could not tell whether he was evoking a depressed object or conveying his own mindlessness, impotence and despair. He might have been communicating what it was like to live in a meaningless world presided over by a sadistic figure. Equally, he might have been interfering with links, whether in the way Bion (1959) described or for fear of discovering a damaging link between himself and others (Cecchi, 1990).[2] Alternatively, he could have been making use of projective identification to evoke his own experience of lacking alpha-function, as Bion (1992: 217) suggested in his *Cogitations*. However this may be, what I wish to highlight is that Jacky had made me feel as overwhelmed as he did, and that this was not in any way modifiable until I achieved some degree of perspective on his terrified need to stick to me in order to survive.

In what follows, I will attempt to think further about this felt paralysis of the clinician's thought processes on the basis of material from two children whose therapists discussed them with me, so that there was the possibility of an additional perspective on the apparent absence of meaningful links.[3] The first vignette concerns Sasha, a child with mild to moderate autism, whose therapist did not notice that his drawing of a door contained the outline of a baby. This child experienced links very concretely as privileged babies who were allowed to exist between the parental couple and who left no room for him. Sasha also had a concept of internal spaces. I will suggest that, unlike many children on the spectrum (see, for example, Meltzer, 1975: 18; Tustin, 1990b: 44), he was able to make use of projective identification, and did so to elicit a state of mind in which his therapist overlooked a baby.

Such a failure to notice something because of the child's projections is of course not the same thing as paralysis. In the case of the second child, Mohammed, whose

autistic withdrawal was much more severe, the therapist felt an overwhelming anxiety that she could recognise no meaningful links in the material, but also that she and the child would forever remain stuck. She described this anxiety as excruciating, and sometimes experienced it as a physical constraint. This child too had achieved the idea of an internal space, but often seemed dominated by the fear that any movement could mean losing a part of his body, so that the free movement of the therapist's thoughts involved in making meaningful links would have posed a severe threat. I had reason to know that both therapists were sensitively in touch with their patients, and not normally in the habit of overlooking meaningful connections.

Sasha: 'evocatory' projective identification and thoughts as rival babies

Sasha began three times weekly treatment with his therapist, whom I will call Mrs. A., when he was three and a half. He was not severely autistic: he had a fair amount of language, and his parents said that he was eager to approach the adults at his special nursery, though he was often overlooked because he did not seem to know what to do to attract their attention. His parents were particularly worried by his obsession with doors, door-handles and hinges, which attracted unwelcome comments whenever they took him out.[4] When Sasha came for his first individual assessment session, this obsession meant that it took 20 minutes to get him to the therapy room. In Mrs. A.'s words:

> *Clinging to the handle of the main door in the waiting-room was the jumping-bean figure of Sasha, yelping and chuntering, "Open da door ... Door shut ... Hullo, it's Sasha ... goodbye", as he tugged open the door, bounced and yelped to the other side, examined the handle, the latch, the hinge, bounced back, banged it shut ...*

Early in his treatment, Sasha would hit and bite his therapist, throw his toys about, cut them in pieces and stamp about the room. Typically he then became concerned about the state of the door hinge: "Oh no, da hinge is broken", only to rush off to tug at the handle of a locked cupboard: "Can-a get in?" Mrs. A. and I wondered how far he was alluding to a fear of being responsible for the severe depression his mother had suffered after his birth, and how far his anxiety about breaking things was responsible for his inability to persevere in opening his box.

Sasha seemed to experience hinges and links very concretely as rival babies. For instance, after some months he stuck the posts of two of his toy gates into a small lump of Play-Doh that he called 'Little Miss Tiny'. He then opened and closed these gates to let a car through so that the 'Little Miss Tiny' bit of Play-Doh was in fact functioning as a hinge. A bit later, when he had been snipping at a piece of string and would have been concerned with damage, he suddenly asked, "Where Nicola?" (his little sister) as though the damage involved her. Mrs. A. and I asked ourselves whether Sasha confused an open door with one that had been broken, as many children on the autistic spectrum seem to do; as though he were faced with the dilemma that an intact 'Little Miss Tiny'-Nicola hinge meant that doors were closed to him, and that he could not open them without doing damage. Such a confusion would go some way towards explaining Sasha's obsessive need to check the state of the hinge-baby on every door he came across.

I will now refer to a session when Sasha was five, when he had been in treatment for just over a year.

Sasha instructed Mrs. A. to pretend to 'be angry', and then began to throw things about in an angry fashion himself. Next, he looked in his box for various things, and

tended to panic and give up if he couldn't find them straight away – "oh, where did I put it?" Mrs. A. found herself getting panicky too – had she failed to put these things back in his box when she was tidying up? – even though she knew that this was not realistic. She then wrote:

> *Sasha drew two parallel lines that might have been a road on a slight incline. Next he drew what looked a bit like a witch's hat. He moved the pencil a bit further up and muttered, "Can't," before drawing what looked like a door. Suddenly, he swept up the sheet of paper, dropped it on the floor, and tried to push buttons on the printer.*

Something had clearly made Sasha anxious. When Mrs. A. asked him to tell her about the drawing, he pointed to the triangle shape and said, "Black". Then she asked about the door shape (see Figure 1). He creaked, "A-a-*a*", as though he were identified with a broken hinge. Mrs. A. started to say that he needed to be sure he could come through her door without breaking it and her. He crumpled the page, looked straight at her, poked the corner into his mouth and sucked. "Dink of water", he said. He seemed to be worried that his 'drinking', too, was potentially damaging.

Now he grabbed the scissors and began snipping off the corners of the page while 'chomping' with his teeth. He cut further bits out of the sides. Mrs. A. watched anxiously: she wanted to preserve this picture but managed to hold back. Then, she wrote, Sasha 'abandoned the picture and fetched himself another sheet of paper, on which he quickly drew a perpendicular line of geometric shapes'. Sasha's anxiety about damage to something precious, which was resonating in Mrs. A., seemed to have become too much for him at this point.

When Mrs. A. showed me the first picture, I saw that the door contained something that seemed to me a clear representation of a baby, though it was drawn in a

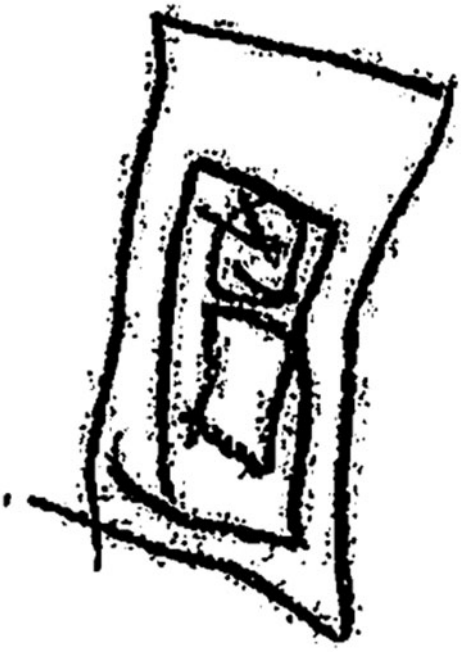

Figure 1. The door with the 'baby', from Sasha's first drawing.

rudimentary way. When I asked Mrs. A. her opinion concerning this part of the drawing, she too thought that there was a baby in the door; so much so that she was very surprised not to have noticed it during the session. When she had asked Sasha about the door shape, he had creaked "A-a-*a*" – might he have thought that the baby in the door was damaged like a creaking hinge? In any case, he retreated to drawing something more abstract. He then attempted to make good the damage done by his 'chomping' and cutting by sticking bits of paper back on – although onto an actual door rather than the picture of one, as though he had become unsure about the 'pretend' status of what he was doing:

> *Sasha found a tiny paper label on the floor. He pressed a lump of Play-Doh on the back. Scurrying to the cupboard, he clambered on to the upright chair and spent several minutes trying the label in different positions. "You are trying to find the right place for that label, aren't you, Sasha?" said Mrs. A. After several minutes he stood on the swivel chair to continue with positioning his label: it looked very unstable, so she stood close by. Sasha pointed at the door hinge: "Oh, no. It not working. It broken," he said, pressing his label on to it.*

Sasha seems worried that his 'chomping' mouth removes an essential bit of the paper that should not be removed. Does having a 'dink of water' mean that he damages a baby-hinge and separates the two parts of his primitive combined object? The physically precarious positions he gets into, and the creaking 'A-a-*a*' sound he makes when Mrs. A. asks about the door, suggest how fragile the structure of his world seems to feel, as well as his identification with the vulnerable 'hinge-baby' that he seems to think he has attacked by 'chomping'.

Earlier in the session, Mrs. A. had resonated to Sasha's fear that something precious was missing, which implies that he was able to use projective identification in order to communicate by evoking feelings or states of mind in the therapist – what Spillius (1988: 83) has called 'evocatory' projective identification. However, although Mrs. A. felt that Sasha's first drawing was important, she did not at the time recognise that he had drawn a baby-like figure inside the door, which, as I have said, was very unlike her. I suggest that Sasha was projecting a state of mind in which babies were overlooked. This may have been an evocation of a depressed mother who could not properly see his potential (an attitude he elicited in the nursery staff as well). Equally, Sasha may have experienced Mrs. A.'s thought processes as her brain children by whom he felt threatened, as Bion (1959) and Britton (1989) have described in psychotic and borderline adults, and he may have tended to interfere with her capacity to think on that account. If so, this was not a mere matter of jealousy: Sasha seemed to experience the privileged hinge-baby as an existential threat because it blocked his way in.

In fact, in the following sessions the theme of babies became much more explicit. Sasha magically concocted a drink by stirring a speck of Play-Doh in a glass of water, as though he were a father 'cooking' with a potent pencil. Later, he marked off an inside space by miming a door in the middle of the room through which he went in and out. By the end of the week, he volunteered that the Play-Doh specks were "ba-*bies*", which he pronounced with a fierce grimace. Perhaps his chomping of these "ba-*bies*" was stimulated by the phantasy that they were an essential ingredient of the milk that a father generated inside a maternal space from which Sasha was excluded – a phantasy similar to the one concerning the 'Little Miss Tiny' hinge.

To summarise so far: Mrs. A. had to deal with urgent anxieties about precious things being lost, perhaps through her fault: anxieties which, as the subsequent material

strongly suggests, Sasha was communicating to her by means of projective identification. In the light of this, I think that her failure to recognise Sasha's first drawing as showing a baby may have been the result of a similar communication: namely, that the presence of a baby (which he seemed to experience as a potential threat) must not be acknowledged. Sasha showed the degree of his own anxiety about the 'baby in the door' when he abandoned his first drawing and reduced the 'baby' to geometric shapes in the second. I would guess that Mrs. A.'s reception and containment of this anxiety contributed to his later ability to bring 'Ba-*bies*' explicitly into the material.

Mohammed: movement as bodily disintegration, and adhesive resonance in the therapist

Sasha's autism was not very severe: he was beginning to conceive of bounded spaces inside a mother figure and, unlike many children on the spectrum, he could make use of communicative projective identification, even if his personification of links as privileged babies remained very concrete. The next child I would like to discuss was much more typical of children with autism: he could sometimes imagine inside spaces and happenings, but easily reverted to the position that Bick (1968) and Meltzer (1974) called adhesive identification and Tustin (1990c) called adhesive equation, in which the child seeks to survive by 'sticking' himself to visible surface characteristics of other people. In this state, any movement can be felt to lead to a catastrophic loss of parts of the bodily self (Tustin, 1972).

Mohammed was born in Britain to immigrant parents. From the age of three, he was looked after by his aunt and uncle. At the time of the first session I will summarise, he was four years old and his therapist, Mrs. B., had been seeing him and his aunt together once a week for some months.

Mohammed had made some important progress in that he would now turn round in the corridor to catch Mrs. B.'s eye through the glass in a door. However, he still ignored her during the session, made no eye contact and covered his ears with his hands when she joined in with his sounds, as though he were worried about being invaded. At the beginning of the session, he took two pieces of Lego over to the window, banged them together and joined them up. He looked out of the window when he heard a bus, and then made sounds like the engine of a bus and its doors opening and shutting.

Mohammed repeatedly fell off chairs in the course of the session. Like Sasha, he persistently tried to open doors and get into cupboards. He easily became frightened of the room, and was very unwilling to go back into it after going to the toilet. Mostly however he stood motionless for long stretches of time gazing out of the window. Mrs. B. felt wiped out; she wished she could see his face. His aunt talked about how desperate she was for him to improve. Mrs. B. felt desperate too: in her notes, she mentioned no fewer than four times how overwhelmed she felt at the idea that Mohammed might remain stuck in an unreachable state for the rest of his life. She felt completely unable to get through to him or to see any meaning in what he was doing. She described 'an excruciating fear of [his] being stuck there doing this for the rest of his life. [He was] looking at me, as though waiting for me to bring him to life, wanting me to do so – and [I had] the feeling that I [couldn't] do it; – [an] extreme fear that he would be stuck'. Perhaps, she thought, she should try seeing him without his aunt: she might not feel so completely wiped out herself.

In fact, from the perspective of someone who was not directly affected by the atmosphere, Mohammed seemed to be communicating a good deal. His use of the Lego evokes to my mind a very primitive intercourse that he appeared to link with the sound of the buses. He was on the alert for glimpses of these buses, and he himself produced virtually continuous 'bus sounds' as though he were becoming the bus. When Mrs. B. showed him a toy car, he put a Lego brick inside it, then determinedly got the brick out again, put it in his mouth and bit it, and threw it away. This play is less elaborated than Sasha's play with the 'Little Miss Tiny' hinge, but again it seems to imply that a favoured rival occupies a privileged space and arouses the child's wish to bite and eliminate it.[5] This bit of play makes sense of Mohammed's apparent fear of being stuck in the therapy room: as though an inside space might trap him or eat him up if he were to penetrate it through biting and throwing away a proto-baby that had occupied it.

Admittedly, these instances of meaningful play were scattered throughout the session. For long stretches of time Mohammed remained immobile, gazing out of the window. I wondered whether he might have been trying to control the movement of the buses – the alternative to control seemed to be falling or the fear of being invaded – and I was struck by the parallel with Mrs. B.'s own 'excruciating' experience of feeling immobilised.

In the event, Mrs. B. decided not to start seeing Mohammed without his aunt: doing so might have mirrored his own apparent conviction that the way forward was to eliminate a third party, whether by biting and throwing away the Lego brick or by wiping out his therapist. Instead, she aimed to co-operate with his aunt in attempting to make sense of his behaviour. The following session took place two months later, at a different time of day.

> *Mohammed seemed very thrown by this change. He bounced around the room making a continuous bus noise, reminding Mrs. B of a bird in a cage. His aunt described how he would come into bed next to his uncle; but now that her husband was working nights, she would find Mohammed next to her in the mornings. Mrs. B. felt that an easy atmosphere was developing between the two adults; but she also experienced a powerful dread that things were stuck. She felt physically constrained and unable to think or to do anything. Interestingly and very uncharacteristically, she did not notice a possible link when Mohammed came and stood close to his aunt just after she had described finding him next to her in bed.*
>
> *An extended sequence followed in which Mohammed looked into the mirror, noticed that his reflection disappeared when he moved away, and spent a while saying "hello" and "bye". He wanted to leave the room, and the adults had to place a chair in front of the door. This seemed to help him to focus: he picked up a crayon and made a mark on some paper, while saying something that had the contour of a sentence.*
>
> *Then, on hearing the noise of a bus, he went to the window to see it, and turned around to catch Mrs. B.'s eye. She felt that this was both to check that she was there and to invite her to look with him at the passing bus. His hand was hovering over his genitals; when his aunt took him to the toilet, he seemed frightened of going. Then there was another bus sound from outside, and he went to the window with an excited little shout, which his aunt said was something new. He noticed another window, and Mrs. B. commented, "Two windows". Mohammed picked up two cars and banged them together, and she agreed that there were two cars, like him and her.*

Mohammed does seem to have experienced the time change as a threat to his sense of 'going on being' that he attempts to counter by ceaseless physical activity (a 'second skin' activity in Bick's terms, 1968) and by producing a continuous 'bus noise' that

Tustin might have called an 'autistic shape' (Tustin, 1984). At the same time, he appears less stuck in that he does several new things. After the adults have enforced the boundary of the shut door, he is able to make a mark on paper, to produce sounds with the contour of a sentence, and to give an excited little shout when he sees another bus through the window. He is also beginning to build meaningful sequences: both when he stands close to his aunt after she has described finding him next to her in bed, and when he responds to Mrs. B.'s comment, 'two windows', by banging two cars together. He even makes eye contact as though to invite Mrs. B. to attend to the bus together with him.

The point I particularly wish to highlight is the bodily nature of Mrs. B.'s response: she felt physically constrained, not just mentally immobilised. It is as though she were resonating with him on an adhesive, bodily level, much as Schore (2000) has described mother and baby 'resonating right brain to right brain'. Similarly, Mohammed seemed frightened that physical separateness held the threat of losing his sense of self or of disintegrating bodily. The sequence in which he repeated 'hello' and 'bye' while playing with the disappearance and return of his reflection in the mirror brings to mind Freud's grandson, who said 'baby *fort*' and 'baby *da*' about his own mirror image (Freud, 1920); the implication being that his own on-going existence was linked to being able to bring back the cotton-reel standing for his mother. I would understand Mohammed's touching his genitals as he watched a bus pass by as the fear that its moving away meant that he might lose part of his own body, or else his body contents in the form of urine. The appearance of another bus would have been a reassurance, and he welcomed it with a new, excited little shout. If this reading of the material were plausible, it would make sense that Mohammed's bodily anxieties should be reflected in Mrs. B.'s bodily feeling of paralysis, and that, like me with Jacky, she should have lacked the mental freedom of movement that is necessary for attaining some perspective on the material.

Discussion

A number of central themes appear in both boys' play, although in a more elaborated form in Sasha's than in Mohammed's. These include a focus on opening and penetrating through doors, and on biting and eliminating rival sibling figures. Both boys are preoccupied with doing damage: in Mohammed's case, his fear of the toilet and the room implies paranoid anxieties concerning the possible consequences of this, unlike Sasha's more depressive concerns about the baby hinge that personifies the link between the parents. But with Mohammed, unlike Sasha, bodily anxieties concerning the loss of body parts and the danger of spilling out play a major role, with the consequence that he is less able to maintain a focus on inside spaces and relies far more on adhesive sticking, on second-skin hyperactivity and on self-generated sensations (Tustin's autistic shapes) such as his continuous humming bus noises.

In her discussion of freezing and immobilisation in children with autism, Tustin (1990a) referred to Selma Fraiberg's formulations concerning small children's response to danger. Fraiberg wrote: 'the behaviour is one of complete immobilisation, a freezing of posture, of motility, of articulation' (1982: 622).

Tustin (1990a: 94–5) agreed with Fraiberg's formulation that immobilisation ('the other face of freezing') 'is a biological defence against the most extreme danger' (1982: 623). She continued: 'My own clinical work has convinced me that both freezing and immobilisation ("playing possum") are psycho-reflex reactions that are

part of our biological heritage'. She thought that these were triggered to protect the child against the extreme bodily anxieties that can accompany the awareness of being physically separate, and which include the fear of falling, of spilling out and of losing parts of the body that can be seen in Mohammed's material. In resonating with such bodily fears in the second session from which I have quoted, Mrs. B. experienced her countertransference anxieties on a bodily level as well: in terms of a physical sense of constraint. This, I think, stands in contrast to the situation in the first session, in which Mohammed was less preoccupied with bodily anxieties and more focused on inside spaces, and in which he seemed to look at her as though asking her to bring him to life. Her feeling of impotence may well have reflected the child's inability to elicit a lively response from parents who did not stay with him. It seems likely to be based in projective identification, in contrast to the strong sensation of physical constraint that Mrs. B. experienced in the second session.

Children operating on this very primitive level can easily confuse the communication of feelings with the loss of their body contents. This has been described by many authors (e.g., Rey, 1979; Tustin, 1986; Grotstein, 2000; Rhode, 2004) as well as in first person accounts (e.g., Gerland, 1996), and, alongside the failure to conceive of inside spaces, may well be one reason why children with moderate to severe autism cannot readily make use of projective identification in order to communicate feelings (see, for example, Meltzer, 1975: 18; Tustin, 1990b: 44). On the other hand, as Durban (2014) showed in the paper I previously referred to, they can and do elicit important bodily countertransference phenomena. The fact that the clinician experiences these on a bodily level may imply the operation of the kind of immediate sympathetic experience that has been described in connection with mirror neurones (Rizzolatti and Gallese, 2003), or, as I have mentioned, in Allan Schore's formulations concerning mother and infant 'resonating right brain to right brain' (Schore, 2000). If this were the case, Mrs. B.'s experience of being physically immobilised would rule out achieving the distance from the material that is necessary in order to gain the sense of perspective required to notice links.

Like Mrs. B.'s response to Mohammed in the first session, Mrs. A.'s containment of Sasha's anxieties about a damaged hinge-baby and the loss of precious objects seem to be based on communicative ('evocatory') projective identification. As I have said, I believe this makes it plausible that Mrs. A.'s failure to notice the baby in the door also followed from projective identification: whether of Sasha's depressed internal mother who could not recognise his potential, or of his own feeling that a sibling figure threatened to displace him and must be eliminated.

Finally, to return to Jacky in the light of these reflections on Sasha and Mohammed: I did not at the time achieve sufficient perspective to conceptualise the immobilisation I experienced as resulting from two different pathways – from my resonance with Jacky's adhesive defences against extreme vulnerability and terror as well as from the projective communication of his sadistic triumph. In the absence of such perspective, one does not recognise that the immobilisation of one's associations is meaningful, and it is easy to feel that nothing is being communicated. In fact, important communications are taking place; but some of these contain an element that paralyses the therapist's ability to associate and to symbolise: there is a difference in the countertransference between those communications that can be thought about and those that cannot. In Mohammed's case, the bodily impact on the therapist of the child's adhesive defences was so great that it obscured his capacity for projective communication. In Jacky, on the other hand, the operation of this adhesive level was

initially masked by the presence of projective identification, and some degree of change only became possible through the simple recognition that his projection of hatred was not the whole story – that sticking to me was a matter of survival.

Jacky's material, like Mohammed's, illustrates the degree to which one level of the personality that is capable of communicative projective identification can remain unintegrated with another level at which adhesive resonance operates. Remaining attuned as far as possible to both these levels is presumably of central importance when our associations are immobilised. My difficulty in doing so with Jacky must have contributed to his outcome at the end of treatment when, as a psychoanalyst who knew his parents put it, he had made many developments but his core had remained untouched.

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Notes

1. Rosenfeld (1971) describes a paralysis that is brought about through the operation of the kind of projective identification first described by Klein (1946), in which parts of the self are split off and evacuated into another person so that they can be disowned, or lodged in another person in order to control them. He particularly stresses the extreme paralysis that is caused by an aggressive form of parasitism, mediated by projective identification. This is obviously different from the communicative, 'evocatory' projective identification with which I am concerned in this paper.
2. The striking regression reported by Jacky's parents suggests that a deficit in establishing links in the first place (Alvarez, 1998) is likely to have been a less important factor for him than it can be for other children on the autistic spectrum.
3. I am grateful to the two therapists for their generous permission to refer to their work.
4. Many children with autism, from Klein's patient Dick onwards, are fascinated by doors and door handles.
5. Similarly, Klein's Dick bit the father doll's head, saying, 'Tea Daddy', which Klein understood as 'eat Daddy'.

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